Masterton Medical - Patient Enrolment Form

*Patient Details (All fields marked with * must be completed)

4 Colombo Road, Masterton – 063700011 – enrol@mastertonmedical.co.nz – EDI mastertn – GP2GP MML Mailroom 123456

ID sighted | Patient NHI

Personal Details*	
Title:	Family Name:
First Name/s:	Preferred/Maiden Name:
DOB:	Gender: Male ☐ Female ☐ Other ☐

Contact Details*		
Physical Address		
Street:	Suburb:	
Town/City:	Postcode:	
Home Phone:	Work Phone:	Mobile Phone:

Postal Address *(Complete if different from Physical Address)*	
PO Box/Street:	Suburb:
Town/City:	Postcode:

Email Address:

I consent to receive messages from Masterton Medical when appropriate re: appointment reminders, results, recalls or health promotions via: Text ☐ Yes ☐ No Email ☐ Yes ☐ No

Ethnicity* - Which ethnic group do you belong to? (tick the space or spaces that apply to you)					
	NZ European		Maori Iwi & Region:		
	Samoan		Cook Island Maori		Tongan
	Niuean		Chinese		Indian
Other (such as Dutch, Japanese, Tokelauan). Please state:					

Country of Birth:* Place of Birth:*

Community Service Card Details*		
Number:	Expiry Date:	Current Winz Number:

Next of Kin/Emergency Contact Details*	
First and Family Name:	Relationship:
Physical Address:	Suburb:
Town/City:	Postcode:
Day Phone:	Mobile/After Hours phone:

Employment	
Occupation:	Employer & Address:

Smoking Status – Smoking status is an important factor influencing health. Please tick the space that applies to those aged 15 and over.

☐ Never smoked ☐ Ex-Smoker ☐ Currently a smoker

Transfer of records

In order to get the best care possible, I agree to the practice obtaining my records from my previous Doctor.
I also understand that I will be removed from their practice register.

☐ Yes, please request transfer of my records ☐ No transfer ☐ Not applicable

Previous Doctor and/or Practice Name:
Address/Location:

SIGNED AUTHORITY*

I am entitled to enrol in Tū Ora Compass Health PHO. I choose to use this Practice as my regular and ongoing provider of general practice/GP/First Level Primary health care services. I am eligible and entitled to enrol because I am residing permanently in New Zealand and meet one of the following criteria *(Tick box that applies to you):

a	I am a New Zealand citizen **OR**	
b	I hold a resident visa or a permanent resident visa (or a residence permit if issued before December 2010) **OR**	
c	I am an Australian citizen or Australian permanent resident AND able to show I have been in New Zealand or intend to stay in New Zealand for at least 2 consecutive years **OR**	
d	I have a work visa/permit and can show that I am able to be in New Zealand for at least 2 years (previous permits included) **OR**	
e	I am an interim visa holder who was eligible immediately before my interim visa started **OR**	
f	I am a refugee or protected person OR in the process of applying for, or appealing refugee or protection status, OR a victim or suspected victim of people trafficking **OR**	
g	I am under 18 years and in the care and control of a parent/legal guardian/adopting parent who meets one criterion in clauses a–f above **OR**	
h	I am 18 or 19 years old and can demonstrate that, on the 15 April 2011, I was the dependant of an eligible work permit holder **OR**	
i	I am a NZ Aid Programme student studying in NZ and receiving Official Development Assistance funding (or their partner or child under 18 years old) **OR**	
j	I am participating in the Ministry of Education Foreign Language Teaching Assistantship scheme **OR**	
k	I am a Commonwealth Scholarship holder studying in NZ and receiving funding from a New Zealand university under the Commonwealth Scholarship and Fellowship Fund.	

MY AGREEMENT TO THE ENROLMENT PROCESS

- **I have read and agree** with the Use of Health Information statement. The information I have provided on the Enrolment Form will be used to determine eligibility to receive publicly-funded services. Information may be compared with other government agencies but only when permitted under the Privacy Act.
- **I confirm** that if requested I can provide proof of my eligibility.
- **I agree** to inform the practice of any changes in my eligibility.
- **I understand** that by enrolling with this practice I will be enrolled with the Primary Health Organisation (PHO) this practice belongs to and my name, address and other identification details will be included on both the Practice and the PHO Enrolment Register.
- **I understand** that if I visit another Provider where I am not enrolled, I may be charged a higher fee.
- **I have been given** information about the benefits and implications of enrolment with the PHO, and their contact details.
- **I understand** that the Practice participates in a national survey about people's health care experience and how their overall care is managed. Taking part is voluntary and all response will be anonymous. I can decline the survey or opt out of the survey by informing the Practice. The survey provides important information that is used to improve health services.

By signing this enrolment I confirm I have read and agree to Masterton Medical's terms and conditions of enrolment and payment policy. I will pay on the day of consultation, unless I have made prior arrangements and set up an automatic payment or winz redirection.

I also confirm I have read the Practice Charter and agree to the terms.

***SIGNED: _____ *DATE: _____**

Or *SIGNED AUTHORITY: _____ *DATE: _____

AUTHORISED PERSON'S NAME: _____ RELATIONSHIP TO PATIENT: _____

An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf.

Health Information Privacy Statement

I understand the following:

1. This practice works with Tū Ora Compass Health PHO, a not for profit organisation that supports the delivery of health care services across the Wellington, Porirua, Wairarapa and Kapiti areas.

2. The information I provide when I enrol at this practice is shared with Tū Ora and the Ministry of Health to establish my eligibility for subsidised health care. When relevant to my subsidy eligibility, information may also be shared with other government agencies such as Immigration NZ and Ministry of Social Development.

3. My health information such as diagnoses, test results, prescribed medications, immunisations, investigations such as breast screening, and other clinical and administrative data may be shared with Tū Ora to enable them to:

   - Provide feedback to GPs, nurses and others in my practice
   - Plan, deliver, fund, monitor, and improve health services
   - Contact me in relation to services I have used, or may wish to use

4. My health information may be shared with other health professionals who are involved in my care. It may also be shared with health agencies involved with publicly funded programmes, including Breast Screening, Bowel Screening, Immunisation and Diabetes.

5. An electronic "Shared Care Record" allows authorised health care providers, such as afterhours GPs and hospital clinicians', access to a summary of my health information, including laboratory test results, medical conditions, allergies, and prescribed medications. I can choose to opt out, but that will mean clinicians involved in my care will not have access to important health information.

6. If I am under 18, or have a High User Health Card, or Community Services Card, and I visit a GP who is not my regular doctor, this practice will be informed of the date of that visit. The name of the practice I visited and the reason for the visit will not be disclosed unless I give my consent.

7. When this practice is audited, I may be contacted by the auditor to check that I have received services. If the audit involves viewing my health information, only an appropriately qualified health care practitioner will view my health records.

8. If approved by an Ethics Committee, health information that does not identify me may be used for health research.

9. I have the right to access my health information held by this practice and Tū Ora. I have a right to ask for it to be corrected if I think it's wrong.

10. My health information will only be held by Tū Ora as long as necessary for it to perform its necessary functions.

11. I understand that individuals and organisations that may have access to my health information are subject to the Health Information Privacy Code, and are required to keep my information secure.
    Office of the Privacy Commissioner | Health Information Privacy Code 2020
    For more information on health information collected by Tū Ora see: www.tuora.org.nz